ENCLOSURE: I

Agenda Item: 32/16

NHS
Bexley
Clinical Commissioning Group

Governing Body meeting (held in public)

DATE: 24 March 2016

Title	**Diabetes Redesign – Review & Recommendations**
This paper is for **Decision**	
Recommended action for the Governing Body	This paper is to be reviewed by a Conflicts of Interest panel, prior to the Governing Body meeting. At the Governing Body meeting we will provide the recommendations from the Conflicts of Interest panel for consideration. **Approves** 1. The recommendations given below (subject to the above).
Potential areas for Conflicts of interest	GPs providing Diabetes Enhanced Services (under contract).
Executive summary	This paper recaps the history of the Diabetes Pathway redesign and makes recommendations for the future development of the pathway to the Governing Body (as supported by a Conflicts of Interest panel). Overall we can see that Bexley has invested in diabetes care and that due to this the outcomes and services for our population are good (when bench marked against our peers). We are therefore making a series of recommendations that are designed to improve (rather than replace) the current services so that we continue to remain ahead of our peers. A summary of the recommendations are: 1. Improving the current Enhanced Services for the 8 Care Processes with GP practices 2. Investment in podiatry services, and consideration on provider for delivery 3. Improving the current Enhanced Services for Education & Training services with GP practices (outcomes basis) 4. Establishing new protocols with acute trusts for discharge of patients (and contract enforcement)

	5. Monitoring and reviews.		
How does this paper support the CCGs objectives?	**Patients:**	Improving health of patients with diabetes.	
	People:	Continue to offer excellent diabetes services.	
	Pounds:	Value for money for the investments.	
	Process:	Ensuring services are improved for patients.	
What are the Organisational implications	Key risks	GP practices may decide not to participate.	
	Equality		
	Financial		
	Data		
	Legal issues		
	NHS constitution		
Engagement	Stakeholders have been engaged to understand the development needs. GP practices and LMC together with other providers (acute and community services) will continue to be engaged.		
Audit trail			
Comms plan	Mainly via GP practices and localities.		
Author: Sarah Valentine Director of Commissioning	Clinical lead:	Executive sponsor: Sarah Valentine Director of Commissioning	
Date	10 March 2016		

Diabetes Pathway – Review & Recommendations
NHS Bexley CCG

9th March 2016

1. Overview and Summary

This paper recaps the history of the Diabetes Pathway redesign and makes recommendations for the future development of the pathway to the Governing Body (as supported by a Conflicts of Interest panel).

Overall we can see that Bexley has invested in diabetes care and that due to this the outcomes and services for our population are good (when bench marked against our peers). We are therefore making a series of recommendations that are designed to improve (rather than replace) the current services so that we continue to remain ahead of our peers.

A summary of the recommendations are:

	Overview of Recommendations		
1	Local Enhanced Service review of terms for the 8 care processes and NDA reporting	a) Restructure the enhanced service to provide greater care for patients (% compliance to care processes), b) Stringent reporting and payment to new KPIs. c) Include the quality management of referrals and discharge of patients from out-patient care.	
2	Podiatry services	a) Small investment £30k? – This will only be available on release of funds from acute care (see later). b) Consider the transfer of service to GP federation to align with Local Care Networks and also the education provider	
3	Education service	a) Review of KPIs to ensure fit for purpose (payment to follow the service actually delivered to an individual (outcome) not to be based on a referral) b) Transfer of Oxleas Diabetic Nurse Specialists to education service provider	
4	Acute Trusts	a) Establish new protocol for discharge of patients (linked to payment) and ensure monitored and enforced. Discharge appropriate patients back to primary care (existing cohort) and then on-going	
5	Monitoring	a) More stringent monitoring of performance and delivery as elements of the integrated services, with remedial action taken for any non delivery. b) Quarterly overview reports provided of the elements.	

2. History & Background

In 2013/14 (quarter 3) a business case was produced for Diabetes care (based on historical benchmarking of spend) which suggested that integrating the pathway could effect a new, more effective, service improving both quality and cost. As part of the business case we recommended using a prime contractor mechanism to integrate the community and acute elements of the pathway for Bexley residents (based on the Super 6 principles – see later). The business case & procurement, which was approved by the Governing Body, aimed to increase the amount of care provided outside of a hospital environment (in partnership with community and general practice) and to reduce the number of non elective admissions. A copy of this Business Case is available on request.

Over the period of the procurement (and intervening years) the QIPP financial target associated with this integration was revised; based on an audit (by a primary care clinician) of out-patient activity at the dissolution of SLHT. The revised figure took account of the potential opportunity for the transfer of suitable patients from an acute to a primary care environment (circa £190k per annum).

The procurement process was abandoned when the last remaining bidder declined to proceed. To ensure service continuity the underlying primary, secondary and tertiary services were extended while the CCG determined the appropriate course of action.

It was decided to try to adopt a negotiated solution to the pathway via an alliance of providers. Since early 2015, the CCG has been in discussion with Lewisham and Greenwich Trust, Oxleas NHS Foundation Trust and Bexley Health Limited, with a view to developing the alliance approach, through which to drive service redesign, with support from Diabetes UK and other local voluntary sector organisations. It was hoped that this would harness and apply some of the learning from the procurement specification. At the request of the providers, the CCG agreed for this to be a provider led approach with the group agreeing to 'touch in' at key points in the discussions and for the "consortia" ultimately submitting a proposal to the CCG for consideration.

Also in the interim the CCG sought to engage with commissioning partners and providers on the correct approach to future service redesign. To this end, the CCG has been involved in a diabetes development group, hosted by public health colleagues at the Council, with a view to developing a shared borough strategic and holistic approach to Diabetes. These discussions have included representatives from all stakeholders including patient representatives and clinicians from the major local providers.

Although the alliance of providers were in negotiation for a number of months there was insufficient progress made on producing a model of care and proposal. At the end of April 2015 the providers were informed of a final deadline for a finalised alliance proposal of June 15th 2015 which would include a redesigned model of care,

financial impact and timelines for implementation. This timescale would allow the CCG to draw together a business case for July 2015 Governing Body so that a decision could be made on the proposal.

A proposal was received from the lead provider (Lewisham and Greenwich NHS Trust) to reform diabetes care for our patients. The proposal was reviewed internally by the CCG and it was felt that there were a number of significant issues in the model of care and therefore the proposal was not suitable for implementation. However, importantly, the providers by signalling their willingness to work together and define a future state, demonstrated considerable commitment and investment to the project. This was deemed a suitable basis from which to start more detailed conversations.

In early June 2015, the CCG initiated a first diabetes stakeholder meeting to review the initial proposal. This meeting included representatives from Lewisham and Greenwich NHS Trust, Bexley Health Limited, Oxleas NHS Foundation Trust, Age UK, Diabetes UK and a number of local patients, supported by CCG teams. At this meeting there was consensus that a more structured CCG led approach was required to ensure swift transformation given the complexity of the pathway which crosses primary, secondary and community care. The group recognised that there are key elements of strength in the approach to diabetes care in Bexley i.e.:

- the strength of GP and patient education,
- good links between voluntary sector, patients and primary and secondary care,
- a history of many years of innovation and
- a ‘can do’ attitude in borough stakeholders.

Stakeholders also felt that much more needed to be done and wished to see expansion in podiatry, psychology, dietetics and access to specialist nursing resource to form an integrated team across the health economy.

The stakeholders were also keen for a review of the GP specification, a strengthening in the role of audit of the 9 care processes for high quality Diabetes care; together with increased focus on disease prevention. It was recognised by the group that all these changes would impact on in the investment profile of spend across the pathway.

In July 2015 a paper was presented to the Governing Body explaining the formation of a series of commissioner led stakeholder workshops that would determine the appropriate model of care. The output from these working groups would be an options appraisal on what changes would need to be made and what models could be considered. In the interim period the Director of Commissioning has presented a range of papers to Star Chamber for discussion.

To determine the future model (and any investment or disinvestments) we need to understand where Bexley is in relation to diabetes care. This paper seeks to answer

these questions, provide benchmarking evidence (where available), and to provide recommendations.

3. Bexley's performance on "Care Processes":

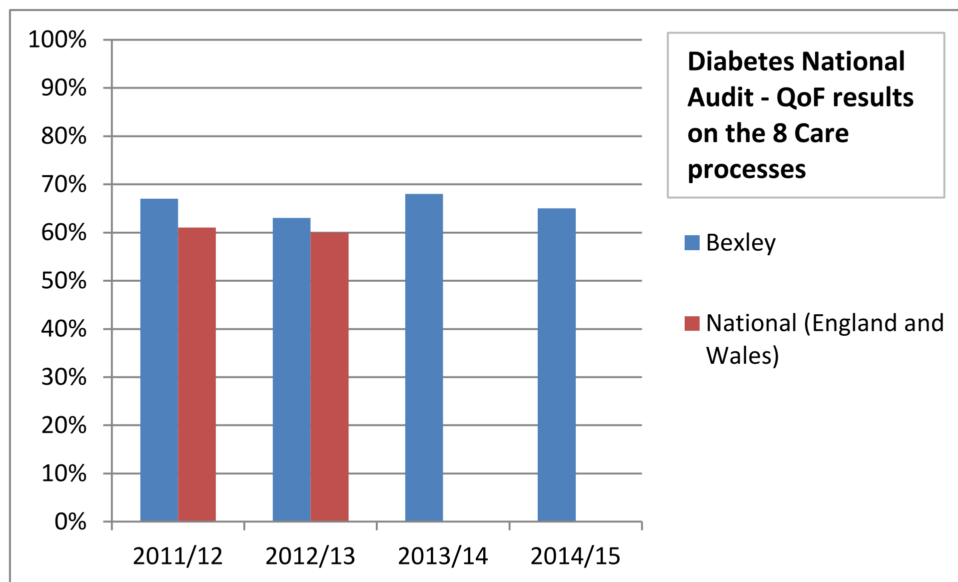
Under NICE guidelines 9 care processes are promoted for the care of diabetic patients and these are shown below. Bexley's performance against the diabetes 9 "care processes" has been strong and ahead of the national averages.

9 care processes recommended by NICE (during a diabetes patients annual review)	
	Weight
	Blood pressure
	Smoking status
	HbA1c (blood glucose)
	Urinary albumin
	Serum creatinine
	Cholesterol
	Eye examination (commissioned via *the retinopathy service and not commissioned via the CCG).*
	Foot examination

The Commissioning for Value performance data has recently been released to the NHS – this further demonstrates that on diabetes care the CCG has strong performance against its peer CCGs:

Commissioning for Value CCG evaluation to peer group (2014/15 analysis)	Average of peers	Bexley CCG
The % of all diabetes patients receiving eight care processes	52	63
The percentage of patients with diabetes in whom the last IFCC-HbA1c is 64 mmol/mol (equivalent to HbA1c of 8% in DCCT values) or less (or equivalent test/reference range depending on local laboratory) in the preceding 12 months	68	72
The percentage of diabetic patients whose last cholesterol was 5mmol or less	69	72
The percentage of diabetic patients whose last blood pressure was 150/90 or less	87	88
Green denotates higher performance levels than the peer CCGs		
Peer CCGs are: Barnet, Basildon & Thurrock, Bromley, Crawley, Dartford Gravesham & Swanley, Havering, Sutton, Swindon, Thurrock and Trafford		

In addition there is the National Diabetes Audit data which practices are asked to submit as part of a Local Enhanced Scheme. This provides information on the 8 care processes. Data for 2013/14 and 2014/15 (national results) is still being compiled but information has been given to each CCG on their own performance.



It is clear from the above that Bexley has historically & continues to perform well on diabetes care.

In Bexley we have an enhanced service with GP practices to provide the 8 care processes, and a key element of this is a requirement to provide the information to the above audit programme (this is discussed later). In addition we have a secondary element to this enhanced service that is for the provision of education and training services. This service has won awards (DESMOND) and is actually now promoted nationally.

Over the past months we have taken the opportunity of looking at models of diabetes care that are promoted nationally.

4. Opportunities and models:

We have looked outside of the CCG for models of care which are promoted nationally, or have won awards: The two that we will focus on are:

- Portsmouth and East Hampshire **"the Super 6"** model of diabetes care (see Appendix 1) and
- North East Essex Diabetes Diabetes Care (**NEEDS model**) – see Appendix 2.

The Super 6 model has been promoted nationally and is an integrated model of care that comprises 6 areas of diabetes care alongside a healthcare professional educator role. The 6 specialist services requiring specialist health care were as follows:

- Inpatient diabetes
- Antenatal diabetes

- Diabetic foot care (anomalies not checks)
- Diabetic nephropathy (dialysis and decline of renal function)
- Insulin pumps
- Type 1 diabetes (individuals with poor control or young people)

It is clear that this is also about integration between specialist, acute and primary/ community care. It therefore also needs the 9 care processes (see above) to support this. Implementing the Super 6 in Bexley was the basis for the original business case of improving outcomes and integration (via a prime contract and integrated model).

The NEEDS model is also being promoted through the 5 Year Forward View, and this is about primary care taking the lead on a model of diabetes care to deliver the 8 care processes, but also to move care into the primary/ community care network (so a refocus away from delivery in the acute environment). The NEEDS model in Essex is "delivered" via a GP federation – with the consultants providing outreach services in GP practices, and care is wrapped around the individual. This could be seen to be closely aligned to the South East London Local Care Network model.

Both of these models are promoted as reducing the reliance on secondary (acute care) and to avoid escalation (which would include avoidable non elective admissions). Benchmarking information for the NHS is limited, but later in this document we make some comparisons to the NEEDs model.

5. The CCG's Spend on Diabetes Care Services:

We have used a programme budgeting method here that includes any admission for a diabetic patient (as the original principles were any admissions for a patient in this cohort). A programme budget method involves analysis across a whole care pathway as opposed to a traditional analysis of contract activity. The chart below reviews the historical spend with acute providers of care – for activity that is recorded within Payment by Results.

Acute spend

Activity grouping	2012/13	2013/14	2014/15
Out Patients New	100,233	112,950	88,147
Out Patients Follow Ups	349,512	365,147	342,166
Out Patients Total	449,745	478,097	430,313
Inpatient electives	2,664,487	2,059,154	1,943,497
Inpatient non electives	5,978,352	6,191,839	6,976,206
Inpatient total	8,642,839	8,250,993	8,919,703
Total Programme Budget	9,092,584	8,729,089	9,350,016

12/13 shows the original programme budget that was the subject of the prime contractor procurement.

We have refined the 14/15 acute programme budget to ensure that the data shown (on in-patients) is for admissions related to a primary or secondary diagnosis of diabetes. This gives the following:

Acute spend

Activity grouping	2014/15 £
Out Patients New	88,147
Out Patients Follow Ups	342,166
Out Patients Total	430,313
Inpatient electives	1,933,951
Inpatient non electives	6,602,804
Inpatient total	8,536,755
Revised budget	8,967,068

We have also removed activity related to bites, burns, stings, births, falls and fractures.

From the above, the acute spend overall has increased (although it is decreasing on elective inpatients), and there is a noticeable increase in non-elective in-patient admissions (£1m). However, analysis of Commissioning for Value (against our peer group) shows that on a programme budget basis our spend on these admissions remains below our peer group.

Commissioning for Value CCG evaluation to peer group (2014/15 analysis)	Average of peers	Bexley CCG
Diabetes emergency & non elective admissions spend - programme budget	1,130.28	981.30

In addition to the acute spend there is money invested in both primary and community care services, this is shown in the chart below.

Non Acute spend

Service Group	Service	Value per annum (max budget)
GP Enhanced Services (this is in addition to contract funding GMS/PMS)	Undertaking the 8 care processes £25.00 per patient	£292,500
	Providing Education and training DESMOND £20.00 per patient	£247,020
Community	Podiatry Service Oxleas	£130,578
	Dietetics services * note 1	£0
	Diabetic nurse specialists Oxleas	£74,644
	Specialist midwives * note 1	
	Age UK toe nail clipping * note 2	£10,000
Sub total		£754,742

6. Benchmarking:

In the following we look at evidence of spend in the acute sector (and any opportunities) together with evidence of the delivery of the 8 care processes. In

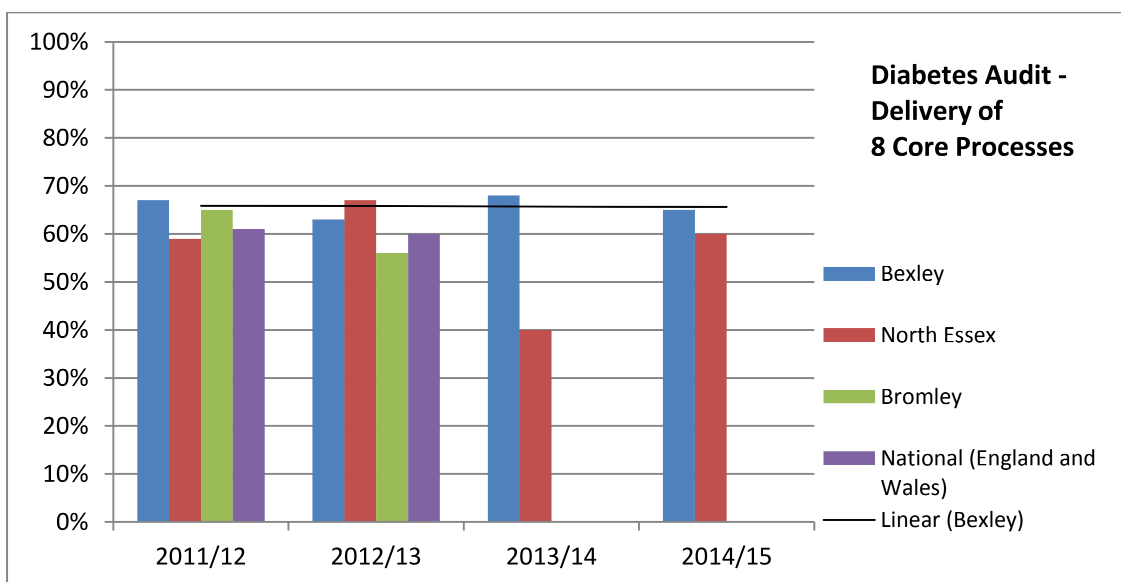
doing this we have also taken the opportunity of comparing ourselves to the NEEDS model in North East Essex Diabetes (described above), Bromley CCG (one of our peers) and the Commissioning for Value peer group of CCGs.

6.1 Delivery of the 8 Care processes:

Commissioning for Value (fuller analysis shown above section 3) shows that we perform above our peer group of CCGs.

Commissioning for Value CCG evaluation to peer group (2014/15 analysis)	Average of peers	Bexley CCG
The % of all diabetes patients receiving eight care processes	52	63

However, we can still improve as information below from the National Diabetes audit demonstrates that improvement can be made (national data for 2013/14 and 2014/15 is yet to be released):



6.2 Acute spend benchmarking

Our total Non-Elective (inc. emergency spend) using Commissioning for Value shows us as having a spend below the average of our peers:

Commissioning for Value CCG evaluation to peer group (2014/15 analysis)	Average of peers	Bexley CCG
Diabetes emergency & non elective admissions spend - programme budget	1,130.28	981.30

However, further analysis of the peer group shows that Bromley CCG have a considerably lower spend in this area (of 619).

Analysis of Better Care Better Value – ambulatory care sensitive emergency conditions for our CCG, North East Essex and Bromley CCGs shows that the opportunity still exists to reduce these emergency admissions (this would be through better prevention, and management):

Ambulatory Care NEL admissions (BCBV)	Bexley CCG			Bromley CCG			North East Essex CCG (nationally promoted model)		
	Rate p100,000	Rank	Opportunity value (pq)	Rate p100,000	Rank	Opportunity value (pq)	Rate p100,000	Rank	Opportunity value (pq)
Q3 2014/15	15.29	5	£25,475	14.82	3	£57,240	21.78	22	£42,664
Q4 2014/15	20.57	24	£50,675	23.04	41	£70,920	28.90	77	£99,965
Q1 2015/16	22.78	55	£66,428	19.91	37	£63,862	Data not available		
Q2 2015/16	25.63	14	£35,782	17.71	16	£58,408	Data not available		
Opportunity pa (based on last 4 quarters)			£178,360			£250,430	Using 2Q x 2		£285,258
ADS registered population 2012			228,388			329,136			327,754
Opportunity pa (p100,000 population)			£78,095			£76,087			£87,034

However, the above shows that we are better than the NEEDs model CCG, and compare well against Bromley.

Bench marking data is not available on our elective in-patient spend.

6.2.1 Out Patients News (First Referrals)

This information is derived from the Better Care Better Value (NHS productivity) information system. We have compared our rates over the last 3 quarters to NEEDs and Bromley:

Out Patient New Rates p100,000	Bexley	Bromley	North Essex
Q4 2015/15	30.6	30.6	42.2
Q1 2015/16	32.7	16.5	38.4
Q2 2015/16	59.4	14.3	36.2
Opportunity value over the 3 quarters	£28,744	£16,154	£44,585

This shows that Bromley has been improving its performance whilst our CCG's performance has deteriorated.

6.2.2 Out Patients New to Follow Up Ratios:

Here we have again used Better Care Better Value, but the system does not allow calculation at a CCG level, only at a provider level. There are varying levels of performance with our main providers (LGT and DGT). A new to follow up ratio is the ratio of follow up appointments for every new attender in consultant clinics. We have again compared our main providers to the main providers for Bromley and also North East Essex CCGs.

It clearly highlights the difference in follow ups for every new between those Trusts.

Out Patients New to Follow Up Ratios (BCBV)	Bexley CCG			Bromley CCG			North East Essex CCG (nationally		
2015/16	LGT	3.62	Q2 2015/16	KCH	11.29	Q2 2015/16	Data not available		Q2 2015/16
2014/15	LGT	6.1	Q4 2014/15	KCH	9.96	Q4 2014/15	Colchest.	2.73	Q4 2014/15
	DGT	2.86	Q4 2014/15						

We have then taken this analysis a stage further to look at the activity charged to Bexley CCG by our main 4 providers.

Out Patient Follow Ups

Diabetic Out Patient 2014/15 PbR activity key analysis	Bexley actuals						Analysis of opportunities				
							Better Care Better Value Trust averages			Reduce to DGT BCBV	
	OP News	OP New £	OP FU	OP FU £	Average FU £ incs MFF	Bexley's OPN2FU ratio	BCBV average for the Trust (all CCGs) Q4 2014/15	Reduction in activity to Trust average	Reduction in £ to Trust average	Reduction in activity to lowest BCBV average in group (DGT)	Reduction in £ to lowest BCBV average in group (DGT)
Dartford & Gravesham	74	£19,018	278	£31,970	£115	3.76	2.86	-66	-£7,631	-66	-£7,631
Lewisham & Greenwich	196	£52,318	1778	£211,701	£119	9.07	6.10	-582	-£69,345	-1,217	-£144,957
Kings Healthcare	34	£9,149	349	£41,880	£120	10.26	9.96	-10	-£1,243	-252	-£30,211
Guy's & St Thomas'	28	£7,662	393	£50,802	£129	14.04	12.35	-47	-£6,101	-313	-£40,450
Opportunities (using 14/15 activity and prices)							100% achievement		-£84,321		-£223,250
							80% achievement		-£67,456		-£178,600
							60% achievement		-£50,592		-£133,950
							40% achievement		-£33,728		-£89,300

Dartford has a very low rate of diabetes follow ups, we know that Dartford have a policy of discharging patients back to primary care which we would need to consider against our investment in the primary care enhanced services – see later.

The chart above considers an analysis of opportunities if we set in place a policy requiring all type 2 patients to be discharged back for all routine follow up appointments, then an opportunity exists. If we adopted this with our 4 main providers we could depending on achievement, seek to reduce our OP follow up charges by £34k to £223k per annum (range low to high).

The clinical audit undertaken at the dissolution of SLHT suggested that there was a quantum within the spend on the follow up of diabetes patients that should not remain within SLHT or its successor organisations (estimated to be £190k per annum and within the above range) and that those patients should be discharged back to primary care. The successor organisation to those patients is Lewisham & Greenwich Trust who took over the diabetes care for patients that were at Queen Mary's (where the audit was undertaken in 2013). It shows that their new to follow up ratio for diabetes care patients remains high when compared to DGT.

The above bench marking suggests that opportunities remain to reduce our reliance on acute trust services through:

1. Continued care in the community of our patients, and education to ensure self management and avoid escalation and avoiding unnecessary admissions.
2. Continued improvement on 8 care process compliance (new stretch targets and contracts to reflect this).
3. Discharge of routine follow up patients to the community within the above.

6.3 Community & Primary Care Enhanced Services Spend:

Benchmarking information on community services spend for diabetes patients is not available on line.

In Bexley we have a Local Enhanced Service (LES) with GP practices for the provision of diabetic care to our patients – the total value available is £45.00 per registered patient. This breaks down into the following two components:

- Educational and preventative training (£20 per referral)
- Care processes (up to £25.00 in total per registered diabetic patient) – but the payment of this element has a first qualifying criteria – which is that the practice must upload data to the National Diabetes Audit (NDA) annually. Only if that is met can the payments in respect of performance against the care processes be met.

We have contacted a range of CCGs (see Appendix 3) to understand if they are funding Diabetes Enhanced Services and if so at what level. The chart at Appendix 3 provides the details that we have managed to gather. We have focused on funding for the 8 Care Processes.

It is difficult to cross reference all of these schemes, but we can find 4 that have a direct correlation to our scheme for the 8 care processes:

Key Comparisons 8 care processes - Enhanced Services

CCG	ES per annum per patient	Note
North East Essex - nationally promoted	£7.32 pp 14/15 rising to £8.14 pp 17/18	Includes OP repatriation
Bromley CCG	£25.00 pp	Includes Stable type 1
Bexley CCG	£25.00 pp	
Tayside	£76.78 pp 1st 12m then £40.96 pa	Includes OP repatriation
All of the above exclude education and training of patients		

North East Essex was established in 2014/15 after a market procurement exercise. The current Bexley LES was agreed historically with the involvement and advice of Diabetes UK.

The Bromley scheme whilst at the same value per patient per annum has a key addition of type 1 patients per annum (stable).

It can also be seen that both the North East Essex and the Tayside model include out patients repatriation.

The chart below gives an analysis for the local SE London CCGs that we contacted:

SE London CCGs - Enhanced Services for Diabetes 8 Care Processes	
Bromley	see analysis above
Greenwich	No individual Enhanced Service
Lewisham	No individual Enhanced Service
Southwark	No individual Enhanced Service

It is interesting that many do not fund an individual Diabetes Enhanced Service (ES) for the 8 care processes.

The above shows that the Bexley ES in primary care on a cost per patient basis considerably outweighs the North East Essex Diabetes services payments for the 8 care processes. NEEDs arrived at the £ per patient within a formal procurement, but also taking into account that this is an Enhanced Service and that components of diabetes care would be included in the primary care GMS and PMS contracts.

It also needs to be noted that the ES investment is also supplemented in Bexley by services provided by Oxleas (diabetic nurse specialist, podiatry) and other providers (Age Uk together with providers of maternity care services) see section 5 for details.

6.4 Benchmarking overview/ opportunities

The above bench marking suggests that opportunities remain to improve services (and the value of the commissioned services) and to reduce our reliance on acute care services through:

1. Continued care in primary care/ the community of our diabetic patients, and education to ensure self management and to avoid escalation and unnecessary admissions.
2. Continued improvement on 8 care process compliance within primary care (new stretch targets and contracts to reflect this).
3. Enhancing the value for money within the Local Enhanced Services (by increasing discharge of appropriate patients from acute care, reviewing of quality of diabetes new referrals to acute care, including type 1 stable patients in the care).
4. Discharge of routine follow up patients from acute to primary care within the above.

7. Findings from the clinical and provider groups (including the CCG's clinical lead for diabetes):

The CCG has been engaging stakeholders, providers and our clinicians in a range of discussions regarding the models of care for these services. The recommendations are summarised below:

1. An integrated model with high quality care of patients with diabetes provided by :-

    - Enhanced GP scheme linked to the care outcomes
    - Nurse specialists in the community and providing patient education
    - Clinical summits and education
    - Secondary care including discharge protocols relating to Type 2

2. Increase the number of patients with diabetes who can be supported in the community through primary care and community providers.

3. Consider the need for additional podiatry services.

8. Conclusions & key findings from the analysis above and recommendations:

We need to recognise that Bexley has won awards in respect of our diabetes services and benchmarking of the 8 care processes is showing positive results, but we need to maintain the quantum and we do need to reflect on the benchmarking findings. The findings demonstrate that the Bexley diabetes services are good, but there is still room for improvement.

Having approached the market we know that there is no single provider willing to take on the integrated care model across acute, community and acute, and that the proposed alliance of providers to accomplish this has not been forthcoming from our existing provider base.

Given this we provide a series of recommendations designed to enhance the existing services:

Recommendation 1 - Enhanced Service (8 Care Process element) Improvement

Renegotiate the enhanced services with our GP practices – to either:

1. Reduce the overall scheme value (cost per patient) based on NEEDS as a bench mark or

2. Maintain the scheme value but establish a set of KPIs with costs for performance delivery for each care process for each patient, and also a payment for the upload of data to the NDA (with a copy given to the CCG). Included in the care must be the requirement to ensure quality referrals to

secondary care, and that patients are discharged back from secondary to primary care for their routine care and checks (see later). We need to ensure that both the care delivered element and the upload element of the scheme (in distribution terms within the £25.00 existing value) are sufficient to ensure delivery. This discharge from acute care services would then fund expansion in podiatry (see later).

Alternatively:

3. Test the market for a supplier of the 8 care processes – we believe that this would be difficult as any provider will need access to the primary care records of patients and QOF data. However should bullet point 2 above not be successful then this would be the secondary course of action.

We recommend 2 above. If however, this negotiation fails, then we would revert to option 3 (to duplicate the North East Essex model).

Recommendation 2: The podiatry service

The podiatry service at Oxleas is 1.7 WTEs (and is also supplemented by Age UK services). Both of these services provide services to non diabetic patients as well (although diabetic care is predominant).

The North East Essex Diabetes population was 333,600 in 2013 so only slightly larger than ours but we also commission the Age Uk service. North East Essex Diabetes considered the podiatry WTE need to be 1 WTE.

However, we may want to consider a minimal investment to extend podiatry increasing the service to 2 WTEs following an analysis of Oxleas waiting time standards. We should also consider whether:

a) it would be best to place those services into a GP practice or the federation for ownership of the service alongside the Local Care Networks
b) to consider discussing the additional investment with Age Uk who may offer a more cost effective solution for expansion

We recommend that both of these recommendations are considered as we seek to implement recommendation 1. However, funding for any expansion to these services can only be achieved if acute funds from out patients are released under recommendation 1.

Recommendation 3: Education

In terms of education we are presuming that in North East Essex Diabetes the investment in 6 diabetic nurse specialists will be one of the key services for delivering education to diabetic patients. Therefore, our spend in Oxleas is equal to 1.7 WTEs (£74644) if this is added to the education enhanced service at £247020 – then there is a budget of around £300k associated with delivering education to our

diabetic residents. Much of the education is provided via the Local Enhanced Service (GP practices sub contracting to Bexley Health Limited) and they may not actually use qualified nurses.

Given this we believe that based on our population the level of investment in this area remains appropriate.

However, to provide a much more integrated service to patients we may want again to consider the transfer of the diabetic nurse specialists from Oxleas to the GP federation community interest company, as through this we can start to more fully integrate education and support. This provides the opportunity of resilience and the benefits of a single organisation. This would then provide a set of cohesive recommendations (1 to 3).

In addition we need to ensure that the KPIs for the enhanced service are stringent and applied. At present the payments are not in respect of the actual services delivered to diabetic patients, and we believe that we should re-focus the budget and the payments to be on delivery of training and education to an individual patient (so on delivery of an outcome to a patient rather than on a referral).

Recommendation 5: Acute hospital spend

We believe that routine follow up care still remains within the acute hospital providers of care and this should be provided within primary care. We need to establish written protocols with each acute Trust for the discharge of our diabetic patients once the initial assessment and care has been provided. We will need to rigorously performance monitor to these standards. This will mean the establishment of a set of New to Follow Up Ratios for Bexley (based on a pathway of care) standardised with our each of our acute Trusts. It will also necessitate the discharge of a cohort of patients back to primary care (within a limited time period).

The existing investment in the Local Enhanced Service in Bexley shown above (recommendation 1) together with the nationally negotiated GMS and PMS will cover for these patients on-going care within the care processes and ongoing general health support.

Any funds that are released through this mechanism will firstly be used to extend the podiatry service the residual funds will be used to support the on-going healthcare needs of our other patients (and to meet our QIPP targets).

Recommendation 6: On-going monitoring

We will need to ensure that the enhanced services are closely monitored for their performance, and payments only made where performance is delivered. We will need to then consider this against our acute spend profile. A full review will be undertaken on a quarterly basis to bring together the service delivery across the various streams (and providers) and to show progress.

	Overview of Recommendations		
1	Local Enhanced Service review of terms for the 8 care processes and NDA reporting	d) Restructure the enhanced service to provide greater care for patients (% compliance to care processes), e) Stringent reporting and payment to new KPIs. f) Include the quality management of referrals and discharge of patients from out-patient care.	
2	Podiatry services	c) Small investment £30k? – This will only be available on release of funds from acute care. d) Consider the transfer of service to GP federation to align with Local Care Networks and also the education provider	
3	Education service	c) Review of KPIs to ensure fit for purpose (payment to follow the service actually delivered to an individual (outcome)) d) Transfer of Oxleas Diabetic Nurse Specialists to education service provider	
4	Acute Trusts	b) Establish new protocol for discharge of patients (linked to payment) and ensure monitored and enforced. Discharge appropriate patients back to primary care (existing cohort) and then on-going	
5	Monitoring	c) More stringent monitoring of performance and delivery as elements of the integrated services, with remedial action taken for any non delivery. Quarterly overview reports provided of the elements.	

We believe that the above will provide a more integrated pathway, which is designed around care and patient delivery. The "hub" for the service will be care around the patient via the GP practice.

A high level project plan for delivery of these improvements is given at Appendix 4.

9. Next Steps:

The Conflicts of Interest Panel are asked to consider the above, if these are supported to recommend to the Governing Body the acceptance of this paper.

If the above recommendations are accepted we will then:

- Advise LMC of the plan for the above
- Discuss the outcome with the stakeholder groups.

Sarah Valentine
Director of Commissioning

Appendix 1

The Super 6 Model of Diabetes Care and what it has delivered 2 years on:

The “Super 6” model of diabetes care originated in Portsmouth and South East Hampshire. The concept is of a bridge between primary and acute hospital care and was developed by primary and secondary care clinicians as a response to their two key issues that were seen as the barrier to improving diabetes care locally:

- Inefficiency’s in the traditional pathway (eg long-term follow up for individuals with diabetes was being undertaken in in specialist clinics at considerable expense) and features of the care were fragmentation, duplication of effort and an absence of structured care planning.
- Variation in the quality of care in primary care.
- Both of the above were seen as contributory factors to higher than expected rates of diabetic emergency admissions and complications.

The underpinning concept is of specialist service delivery which comprises six defined areas of diabetes care alongside a healthcare professional educator role that would be used to support the development of enhanced skills within primary care that would enable improved patient care and case management for complex needs, and shift the majority of diabetic outpatient activity to primary care. The 6 specialist services requiring specialist health care were as follows:

- Inpatient diabetes
- Antenatal diabetes
- Diabetic foot care (anomalies not checks)
- Diabetic nephropathy (dialysis and decline of renal function)
- Insulin pumps
- Type 1 diabetes (individuals with poor control or young people)

A Consultant and a Diabetic Nurse Specialist offered professional support to primary care –virtual, out of hours and with each practice getting 2 visits a year in order to support the patients out - patient care within a primary care setting. Patients were formally discharged from out-patient clinics by Diabetologists and the Diabetic nurses Specialists back to the primary care practice. Community and Diabetic Nurse Specialists supported the GP at Primary Care level.

Initially during November 2011, 53 of the 80 practices engaged, but this is now 100%. More than 90% of diabetics attending diabetic out-patient clinics were transferred from the clinics to the GP (978 people). The cost of a follow up appointment at £90.00 approximately resulted in savings of about £90k per annum (source - Diabetes and Primary care Vol. 15, No 4, 2013) and “new” patients have reduced by 150 %. Individualised care management of complex needs has reduced NEL in Diabetes care. The 9 care processes are undertaken at the primary care level along with case management and prescribing support.

Appendix 2

The North East Essex Diabetes CCG Model of Diabetes Care (NEEDs).

The North East Essex Diabetes Diabetes Service is a primary and community care based service that reflects the above approach and funding has been based on a reduction of outpatients in secondary care. The service includes primary prevention of diabetes, using checks for the early detection of potential diabetes through monitoring of BMI and impaired glycaemic control, together with the responsibility for ensuring that
the eight care processes (excluding retinal screening which is a national programme) are undertaken annually for all Diabetic patients.

The Service Provider is required to keep a scorecard of these, and to develop individual treatment targets for those people whose needs are more complex, which may require more frequent monitoring than the annual checks for stable diabetics, and to case manage those people more likely to develop the complications of diabetes, that occur more frequently than in the non-diabetic population, namely:

- Angina
- Myocardial Infarction
- Heart Failure
- Stroke
- Major Amputation (above the ankle)
- Minor Amputation (below the ankle)
- Renal Replacement Therapy (ESKD)

The model is integrated using a GP Federation (as the delivery vehicle) with out of hospital care (and consultants, nurses etc. supporting the primary care staff and patients within GP practices).

The model is promoted under the 5 Year Forward View as a model of integrated care services. A set price per patient diabetic patient registered is paid and the payments are based on services delivered to those patients. It is delivered via a 5 year contract with the GP federation.

Appendix 3: Bench marking for Enhanced Services funding for the 8 Care Processes with primary care:

Diabetes Enhanced Services Information

Comparison	Local Enhanced Service budget per patient	Type 1 patients	Type 2 patients	8 care processes (with KPIs)	NDA audit	Annual review	case manage ment	Insulin initiation	Education and training	Any other notes
Bexley CCG	£25.00 per diabetic patient	no	yes	yes	yes	yes	Yes	No	Separate payment £20.00 per patient.	Diabetic nurse (adults) and podiatry services funded with Oxleas
North East Essex CCG (promoted by 5YFV and Diabetes UK)	£7.32 per diabetic patient in 14/15, rising to £8.14 in 17/18	Yes (referral to education only)	yes	yes	yes	yes	yes	no	Part of an additional funding budget for out of hospital care and podiatry	Super 6 model processes included but additional funding for staffing to deliver outside of budget (education, consultants and podiatry). LES costs include repatriation of out patients to primary care
Bromley CCG	£25.00 per diabetic patient	Yes if stable	yes	Yes	Yes	Yes	Yes *	Cost per patient increases to £40 where insulin initiation is undertaken	Available outside of Primary care	* also supported by out of hospital consultant diabetologists in community clinics
Greenwich CCG	No diabetic LES except education currently under development							no	Enhanced service for this	Value unknown for education & training
Dartford Gravesham & Swanley CCG	Information requested but not provided									
Lewisham CCG	No specific diabetic LES but there is a enhanced service for all complex care patients							no	Not through primary care	
Southwark CCG	No specific diabetic LES through GP federations looking at population based extended service contracts with the federation									
Brighton & Hove CCG	£41.79 per diabetic patient (new model from 2016-17)	unclear	Yes	no	yes	yes	no	no	Not through primary care	Also currently paying a one off practice payment of £30 per practice for NDA upload. New model from 16-17 planned.
Kingston CCG	No specific diabetic LES but there is a enhanced service for all complex care patients							no	Not through local commissioned service	
Sutton CCG	They are undertaking a review for these services									They have 1 practice providing consultant level care at a fixed cost per annum.
West Sussex CCG	Level 1 (£56.00) and level 2 (£44.00) enhanced care	yes	yes	yes	No	yes	yes	£130 one off payment per patient for insulin	yes	One year only – shared care model
Berkshire CCG (Now superseded by Berks West Federation model)								£208.39 per patient (new service costs not known)	Unknown	Cost paid includes accreditation and audit
Tayside CCG	£76.78 pp for 1st 12 months, then £40.96 pp pa	No	Yes	yes	no	yes	yes	yes	Referral to education and training but not delivery	New scheme - includes repatriation of Out Patients to primary care

Appendix 4 – High Level Project Plan

Diabetes Redesign - high level project plan 2016/17		April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
1. Enhanced Service 8 Care Processes	1.1 Develop outline changes to service specifications												
	1.2 Give notice of intent to change to all GP practices												
	1.3 Engage with GP practices and also LMC on changes and benefits												
	1.4 Finalise new KPIs and commence changes (old contracts to expire 30.09.16)												
	1.5 Commence new contracts for GP 8 Care processes enhanced services												
	1.6 If the above fails then move into competitive procurement												
2. Podiatry Services	2.1 Review opportunity of transferring services into Education Enhanced Services												
	2.2 Ensure release of additional investments (dependent on 4.3)												
	2.3 Seek additional podiatry services (commission)												
3. Enhanced Service - Education and Training	3.1 Develop outline changes to service specifications (outcomes specification)												
	3.2 Give notice of intent to change to all GP practices												
	3.3 Engage with GP practices and also LMC on changes and benefits												
	3.4 Finalise new KPIs and commence changes (old contracts to expire 30.09.16)												
	3.5 Commence new contracts for Enhanced Services Education & Training												
	3.6 If the above fails then move into competitive procurement												
4. Acute Trusts	4.1 Provide notice of intent (formal) to acute Trusts (and potential impact assess.)												
	4.2 Develop specification for on-going diabetes care and discharge												
	4.3 Implement a contract variation (in year) with each Trust (6 months notice)				1st								
	4.4 Final date that contract variation becomes effective												
5. Monitoring and reporting	5.1 Quarterly update reports on project (via EMC)												
	5.2 On-going monitoring for new services (acute and primary care)												